The Policy Environment Score

Measuring the Degree to Which the Policy Environment in Jamaica Supports Effective Policies and Programs for Adolescent Reproductive Health: 2002 Round

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Abbreviations

ARH	Adolescent reproductive health
ECP	Emergency contraceptive pills
HFLE	Health and family life education
IEC	Information, education, and communication
MOE	Ministry of Education
MOH	Ministry of Health
NFPB	National Family Planning Board
NGO	Nongovernmental organization
PAS	Political-administrative system
PES	Policy environment score
PIOJ	Planning Institute of Jamaica
STD	Sexually transmitted disease
STI	Sexually transmitted infection

I. Introduction

Purpose

The Policy Environment Score (PES) is intended to measure the degree to which the policy environment in a particular country supports the reproductive health of the population, with particular focus on access to high-quality family planning and reproductive health services. It is designed to reflect both the level of support and changes that take place during one to three years as a result of policy activities. This score has two major purposes:

1. To indicate the current status of the policy environment including the strongest and weakest elements.
2. To evaluate the impact of policy activities.

Definitions

For our purposes, we define policy to be actions, customs, laws, or regulations by governments or other social/civic groups that directly or indirectly and explicitly or implicitly affect fertility, family planning, or reproductive health. This definition excludes population policies affecting overall mortality, migration, and spatial distribution but includes health policies affecting all aspects of reproductive health and extends earlier definitions (Maguire, 1990) to recognize that policies can be direct or indirect and explicit or implicit.

II. Conceptual Framework

Local governments and international donors have a history of supporting activities designed to improve health in the developing world. Among the many lessons learned from this experience is that a supportive policy environment is a major factor in the success of most national programs (Clinton, 1979; Freedman, 1987; Merrick, 1989). USAID and other donors have supported population and health policy activities for the past 25 years. There now exists a large and diverse literature base concerning the components of the policy environment and how the various elements interact to affect services and outcomes. In 1994, the USAID-funded EVALUATION Project addressed the issue for family planning activities with a working group on population policy indicators. A considerable amount of background research was done in preparation for the working group. Much of the following discussion expands on the report of the working group (Knowles and Stover; 1995).

The policy environment is defined as the factors affecting program performance that are beyond the complete control of national program managers. In addition to political support and other expressions of national policy (e.g., a formal national policy), the policy environment includes those aspects of operational policy that involve decisions at a higher level than the program (e.g., the program's organizational structure, its legal/regulatory environment, the resources made available to it, and its use of provider and acceptor payments and fees).

Figure 1 presents a conceptual framework for evaluation of the policy environment. The framework is organized according to the standard Input-Process-Output-Outcome schema and depicts policy activities of a single period as part of a continuous circular loop. The policy environment is the output of the policy process. It directly affects the various functional areas of programs (e.g., information, education, and communication (IEC); training; commodities and logistics; management; institutionalization; self-sufficiency; and demand for services).

Inputs to the policy development process include

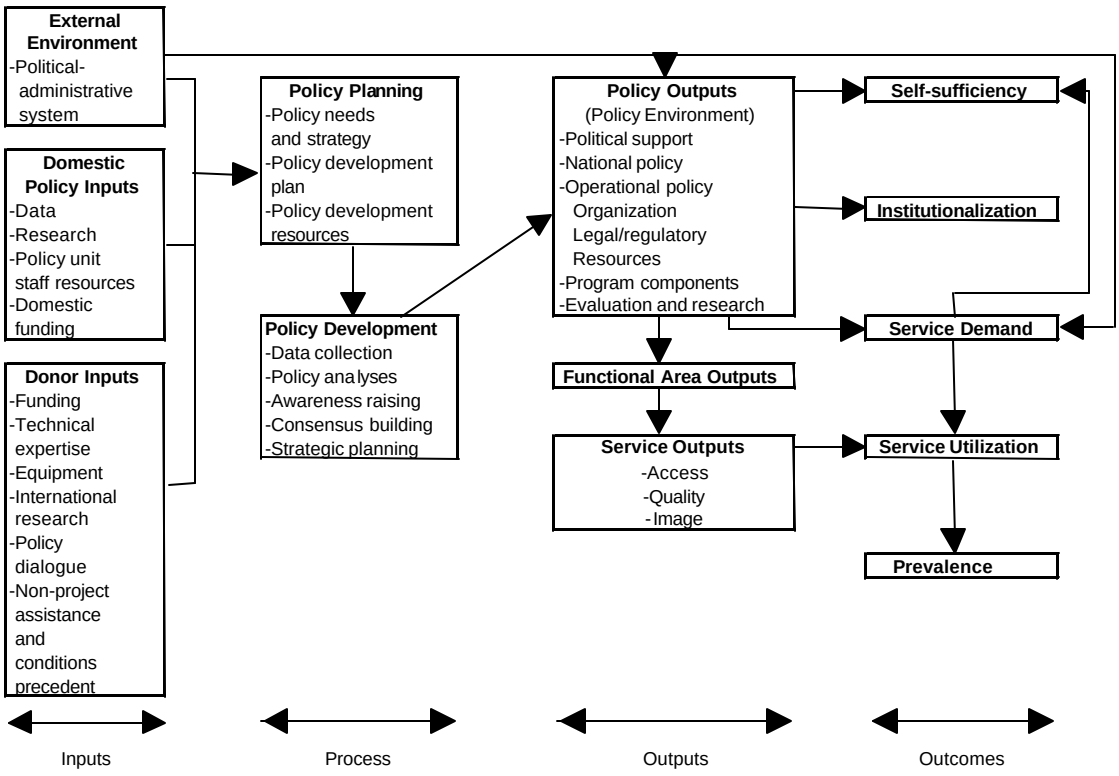
- The external environment;
- Domestic policy inputs; and
- Donor inputs.

The external environment includes a country's political–administrative system (PAS), its socioeconomic characteristics, and its sociocultural environment. Domestic policy inputs include available data, existing research, staff resources of policy units, equipment (e.g., computers and audio-visual equipment), and domestic funding. Domestic inputs are enhanced over time to the extent that the institutionalization of policy development capabilities is an effect of policy work. (Figure 1, as a single-period schema, does not explicitly show the feedback effect from institutionalization in one period to levels of domestic policy inputs in the following period; however, this should be considered as part of the conceptual framework.) Donor inputs to policy development include specialized technical expertise, equipment, funding, international research, policy dialogue, nonproject assistance, and conditions precedent to loans and grants.

The policy environment is modified over time through the planned implementation of policy activities (i.e., the process of policy planning and policy development). Policy planning is based on an assessment of the current policy environment in relation to program needs and of the inputs available for further policy

development. Many policy development activities, or policy interventions, are designed to strengthen political support and/or to develop an effective national policy in support of reproductive health programs. As support for programs grows at the national level, policy interventions are usually directed to strengthening the operational policy environment.

Figure 1. Conceptual Framework for the Evaluation of the Policy Environment



As shown in Figure 1, the external environment (directly), other policy inputs (indirectly) and the process of policy development determine a national program's policy environment. The dimensions of the program policy environment, which is the output of the policy development process, include the following:

- Political support
- National policy
- Operational policy
- Program components
- Evaluation and research

Political support at national, regional, and local levels plays a central role in a program's policy environment since it is an important determinant of the other dimensions of the policy environment. Political support can be both explicit and implicit. Explicit support may be indicated by statements made by high-level government officials and other leaders in support of reproductive health programs. Implicit political support is most often gauged by what the government actually does in the areas of national and operational policies.

National policy includes both formal statements of policy (e.g., national policies and national development plans) and tax and other material incentives designed to affect decisions.

Operational policy consists of three subdimensions that are directly related to the operation of national programs:

- *Organizational structure and processes*: a program's status within the government's administrative structure and its capacity to mobilize the resources of other public and private institutions.

- *Legal/regulatory environment*: taxes and other restrictions that affect the supply of commodities, particularly from the private sector, and medical barriers to service delivery and information activities.

- *Provision of resources*: financial, material, and human resources needed by programs.

Program components is intended to explicitly capture whether specific program components are included in the program by formal policy. This could be included under national policy; however, it seems better to separate it from the broader national policies.

Evaluation and research is intended to capture whether these activities are present to support the process of policy formulation.

According to Figure 1, improvements in the program policy environment should lead to stronger service delivery (access, quality, and image), increased service use and behavior change, and enhanced institutionalization and self-sufficiency of programs. As noted above, institutionalization also affects levels of domestic policy inputs in the following period (a feedback loop). On the supply side, therefore, the policy environment contributes directly to both improved service delivery in the short run and enhanced program sustainability in the long run. On the demand side, both political support and national policy dimensions of the program policy environment (e.g., statements of leaders) affect demand for services.

This framework has been used to develop the major categories for the PES shown below.

Composition of the Policy Environment Score

All of the items in the conceptual framework could be included in the PES. However, we have chosen to limit the PES to those items that both define the policy environment and can be influenced by policy activities.

Items in the conceptual framework (Figure 1) listed under *External Environment* and *Donor Inputs* are assumed to be outside the potential influence of policy activities. Therefore, they are not included in the PES. It could be argued that they should be included since they do help define the environment for policy; however, since they cannot be affected by policy activities, their inclusion would reduce the usefulness of the score as an evaluation device.

Items under *Domestic Policy Inputs, Policy Planning,* and *Policy Development* are the inputs and processes used by policy activities to affect the environment. Therefore, they do not belong in a measure of the environment itself.

Items under *Policy Outputs* represent the elements of the policy environment that policy activities attempt to influence. These items define the categories of the PES:

- Political support
- National policy (or policy formulation)
- Operational policy
  - Organization and structure
  - Resources
  - Legal/regulatory
- Program components
- Evaluation and research

A number of specific items could be included under each of these headings. Selection of items included in the PES is intended to capture the most important indicators in each category.

In Jamaica, the PES has been used to assess four separate reproductive health programs, including:

- *Family planning:* programs to provide high-quality family planning services to men and women who wish to plan their families.
- *Safe pregnancy:* programs to ensure that pregnancies are as safe as possible by providing good prenatal, postnatal, and delivery care and by identifying and treating high-risk pregnancies.
- *STDs/AIDS:* programs to control the spread of sexually transmitted diseases (STDs), including HIV (the virus that causes AIDS), and to ensure the human rights of individuals affected by HIV/AIDS.
- *Adolescents:* programs to enhance the reproductive health of adolescents through education and services.

III. Implementation of the Policy Environment Score in Jamaica

Prior to 2002, two rounds of the PES had been fielded in Jamaica, the first in 1999 and the second in 2000. These rounds were conducted by the POLICY Project on behalf of USAID/Kingston (McClure et al., 2000; Strachan et al., 2001). Those rounds of the PES included four components of reproductive health, namely family planning, safe pregnancy, STDs/AIDS, and adolescents.

This 2002 round of the PES, conducted jointly by Youth.now and the POLICY Project, focuses exclusively on adolescents. Called the *Expanded* ARH PES, the 2002 round included the same questions regarding adolescent reproductive health (ARH) that were used in 2000 and 1999 (hereafter referred to as the "original" ARH PES) and also included a number of additional questions to more accurately reflect the policy environment for ARH in Jamaica in 2002, given policy and program activities undertaken over the past few years (hereafter referred to as the "expanded" ARH PES).

The 2002 Expanded ARH PES included the seven components of *political support, policy formulation, organizational structure, legal and regulatory, program resources, program components, and evaluation and research.*

To measure change in the policy environment, respondents were asked to rate each item twice—once to reflect the current status in 2002, as well as once to indicate the status one year earlier in 2001. The complete Expanded ARH PES instrument is in Appendix B.

Data Collection

A total of 44 respondents participated in the survey between November and December 2002, out of 60 contacted. Appendix A lists the respondents. Several respondents did not answer all of the questions for components about which they were not familiar. Therefore, individual and component scores reflect the number of responses per question. Overall scores reflect the responses of people who answered a majority of the questions. If one respondent did not answer any of the questions in one category (i.e., *political support*), the overall score will not include this person's responses.

Respondents were chosen because of their knowledge about the adolescent reproductive health program and because they represent various viewpoints. Thus, respondents included those working within the public sector programs as well as those outside those programs. Respondents included staff of the Ministry of Health (MOH), the National Family Planning Board (NFPB), nongovernmental organizations (NGOs), the University Hospital of the West Indies, the private sector, and international donors. There was some overlap in respondents in the 1999 baseline survey, the 2000 follow-up survey, and this survey.

In inviting them to participate, respondents were contacted by telephone, email, or in person. Forms were delivered or emailed to respondents in the Kingston region and faxed or emailed to those in other parishes. Follow-up contact ensured that all respondents completed and returned the forms. Some participants failed to complete the questionnaires following review, and some referred them to colleagues who were already respondents. In some cases, assistance was provided to respondents in interpreting the questionnaire. The entire process took place from November 2002–January 2003.

Respondents were asked to provide information on ARH for 2002 as well as the same information for 2001.

Scoring

All of the items in the PES are scored on a 0–4 scale. The definition of the scale varies somewhat depending on the category (as shown in the Expanded ARH PES questionnaire in Appendix B) in order to provide clear guidance to the scorer. For analysis of the "original" ARH PES (that compares to the 1999 and 2000 rounds), only questions in plain type were included. For analysis of the "expanded" ARH PES, all of the questions (the additional questions are indicated by *italics* on the questionnaire), with the exceptions of I.1, I.4, I.11, II.1, and II.8 were included. Questions I.1, I.4, I.8, and II.1 were excluded from the analysis because the same information was asked in more detail in other questions, and question II.8 was excluded because it was inadvertently redundant with question II.7.

The first step in calculating the total score is to sum the individual item scores within a category. These subtotals are converted to averages by dividing by the number of items that were scored. (This procedure computes an average score per item scored; thus, items that were not scored by the respondent do not reduce the score.) These averages are converted into percentages by dividing by the maximum possible score for each category. This approach standardizes the categories so that the number of individual items within a category does not affect its contribution to the total score.

The sum of all the weighted category scores is the total ARH PES. The final score is adjusted to range from 0–100, with 100 indicating a perfect policy environment.

Results

The results section of this report presents and discusses results of the 2002 Expanded ARH PES in Jamaica. This report thus serves as a baseline for the Expanded ARH PES. For comparison purposes with the previous rounds, the "original" questions are analyzed to assess trends in the original items. This analysis is found in Appendix C.

Scores for each component of the Expanded ARH PES are shown in Table 1 (Figure 1 shows the information in graphic form). The total Expanded ARH PES increased from 51.0 percent of the maximum of 100 percent in 2001 to 58.3 percent in 2002.

Table 1. Comparison of Expanded[1] Adolescent Reproductive Health (ARH) Policy Environment Scores (PES) by Program Components: 2002/2001

Component	2002	2001	Change (in % points)
All components	**58.3**	**51.0**	**7.3**
Political Support	70	61	9.0
Policy Formulation	69	59	10.0
Organization	56	47	9.0
Legal and regulatory	55	49	6.0
Resources	44	41	3.0

Programs	54	47	6.0
Evaluation and research	60	53	7.0

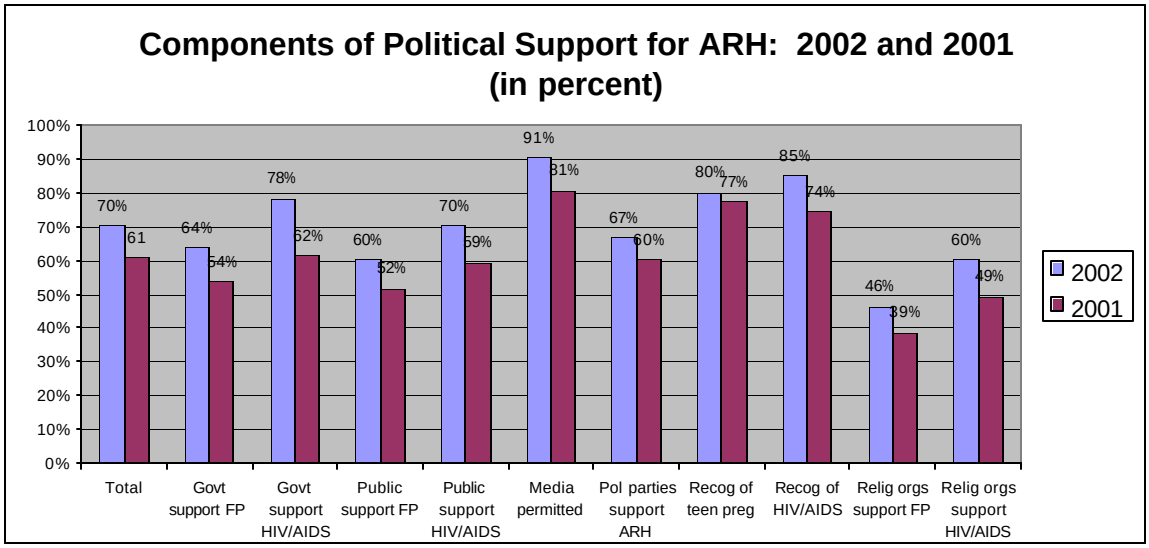
Note: Values can range from 0 – 100.

[1]The Expanded ARH PES includes original questions from the 1999 and 2000 rounds of the PES and additional questions added on ARH in 2002

The ARH PES was rated 7.3 percentage points higher for 2002 than for 2001, indicating that respondents see a small positive trend in the policy environment for ARH in Jamaica. Scores increased in all components of the PES. In 2002, only one component, political support, achieved a score of 70 percent. This category also showed significant improvement, with an increase of 9 percentage point between 2001 and 2002. The other six components received scores between a low of 44 percent for the resources component to 69 percent for policy formulation. The scores for the components changed from 2001 to 2002 at different rates, from a high of a 10 percentage point jump in the policy formulation component to a low of a 3 percentage point rise in the resources component.

Political Support (61% in 2001 and 70% in 2002).

Political support was the highest ranked component in the Expanded ARH PES at 70 percent. Respondents noted significant improvement over time, with a 9 percentage point increase.

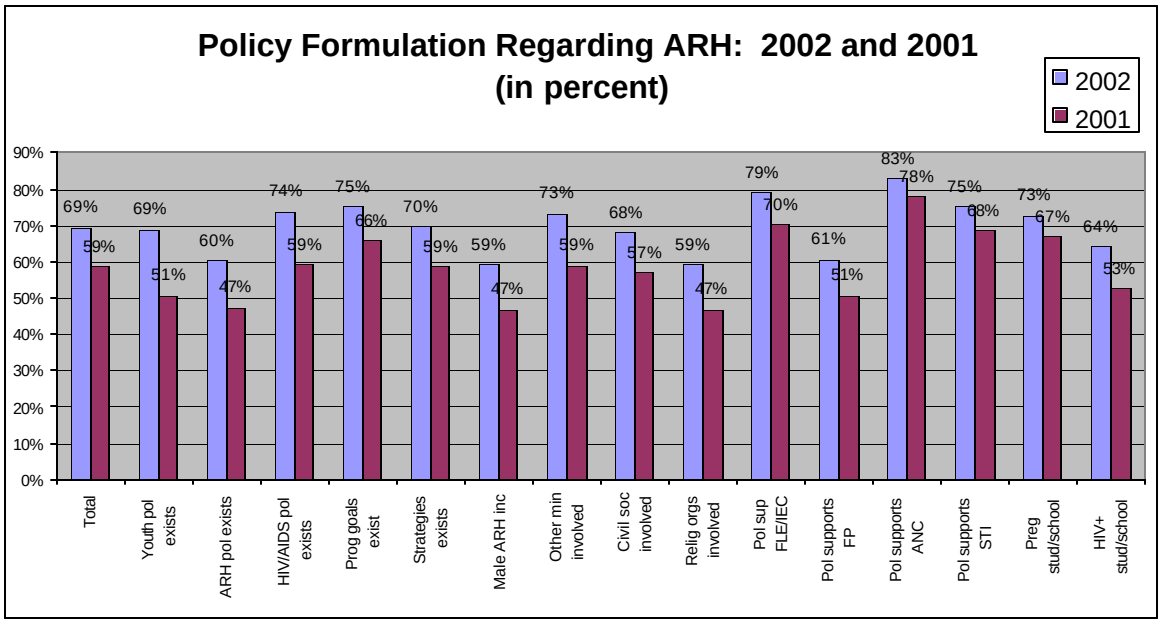


Note: The complete list of items in each component is found in the ARH PES questionnaire in Appendix B.

High-level national government and political party support for effective policies and programs for HIV/AIDS among adolescents received the highest scores, and the change over time was statistically significant. Use of the media to reach youth with RH and HIV/AIDS messages is clearly allowed (that item received a score of 91%). Other items that received high scores included recognition of HIV/AIDS as a problem by top planning bureaus (85%) and recognition of teen pregnancy as a problem (80%). Respondents did not perceive that religious organizations offer much support for family planning (46%) although they are considered more supportive of HIV/AIDS programs for youth (60%).

Policy Formulation (59% in 2001 and 69% in 2002).

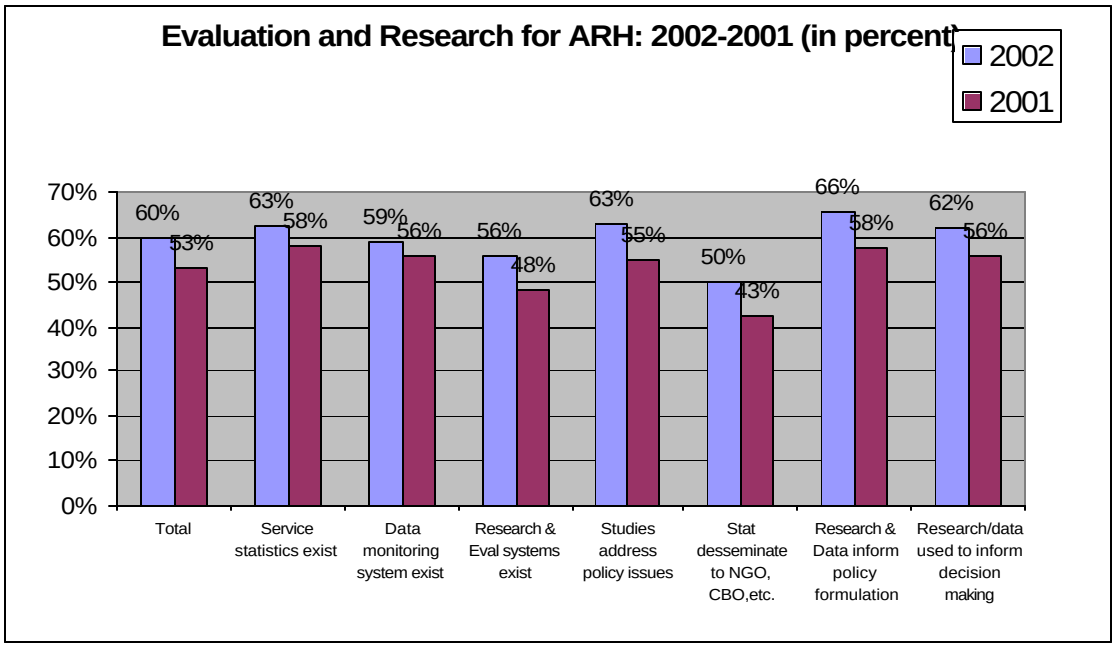
Policy formulation is the second highest ranked category at 60 percent of the maximum, improving 9 percentage points between 2001 and 2002.



Improvements were noted for all aspects of policy formulation. The 18 percentage point difference in the category that indicates that a favorable national youth policy exists reflects the effort that is being made to put a national youth policy in place. Respondents considered the policy support for adolescents receiving antenatal care as good (83%). Areas that scored low in the policy formulation component were that an ARH policy exists, that males are included in ARH, and that policy formulation and dialog involves religious organizations (those items received scores of 60% or less in 2002).

Evaluation and Research (53% in 2001 and 60% in 2002)

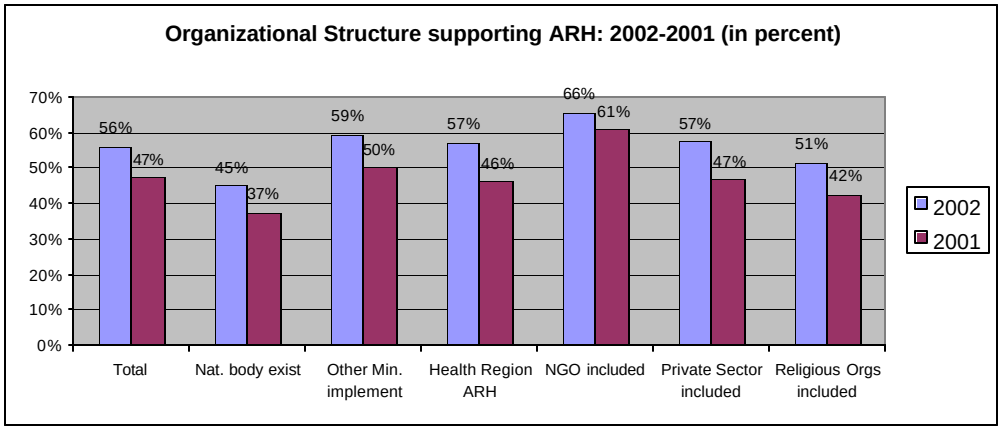
The score for the evaluation and research component rose 7 percentage points between 2001 and 2002 to 60 percent.



The highest rated items in the research and evaluation component are that research and data inform policy formulation, that a system of service statistics exists, and that studies address policy issues (the first item received 66% and the other two items each received 63%). All of the items in the evaluation and research component showed some levels of improvement, particularly that a research and evaluation system exists, that special studies address policy issues, and that statistics are disseminated to NGOs, CBOs, and other organizations.

Organizational Structure (47% in 2001 and 56% in 2002)

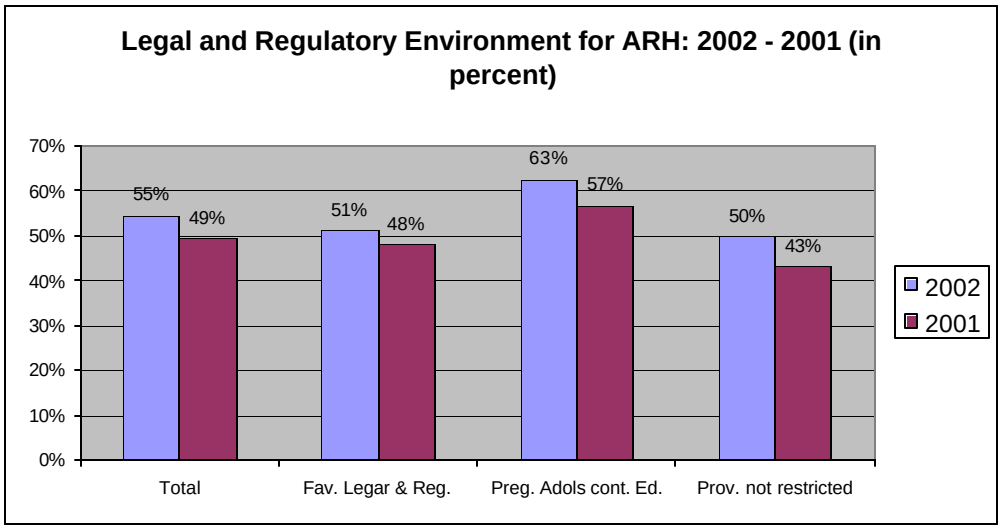
Organizational structure is the fourth ranked component for the Expanded ARH PES, with a score of 56 percent in 2002. This component showed a 9 percentage point rise between 2001 and 2002.



Respondents' perception of a mechanism at the health region level to coordinate planning, resource allocation, and implementation of ARH activities is a contributing factor for this increase in the score for organization. Improvements in the inclusion of NGOs and the private sector in policy deliberations and multisectoral implementation of the program also contributed to the increase in score. Respondents perceived, however, that there is a need for a national coordinating body that will engage various ministries to assist with appropriate services.

Legal/Regulatory Environment (55% in 2002 and 49% in 2001)

The legal and regulatory environment was ranked fifth among the components of the Expanded ARH PES, at 55 percent in 2002, a 6 percentage point rise from the 2001 score.



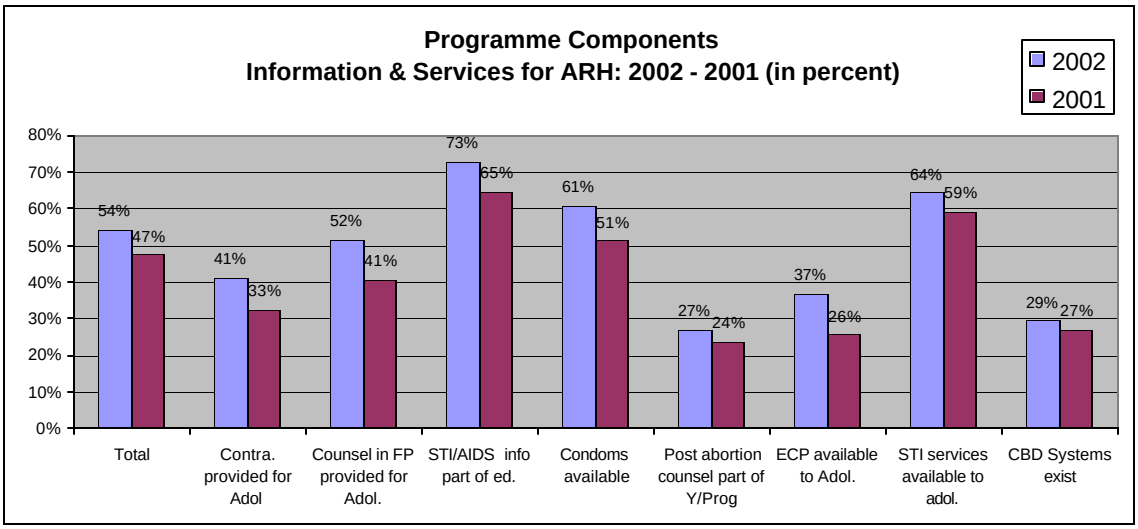
All items in this component improved, particularly that pregnant adolescents are able to continue school and that providers are free from unnecessary legal and regulatory restrictions. The improvement in this last item is interesting in light of the stalled attempt to provide MOH staff with guidelines on serving adolescents (guidelines that were drafted were tabled in parliament).

Program Components (47% in 2001 and 54% in 2002)

The items in the program component have been broken down into five subcategories: information and services, training and service delivery, health and family life education, adequate targeting of vulnerable groups, and NGO participation. The 6 percentage point increase in program components can be attributed to overall improvements in each of the five sub-categories.

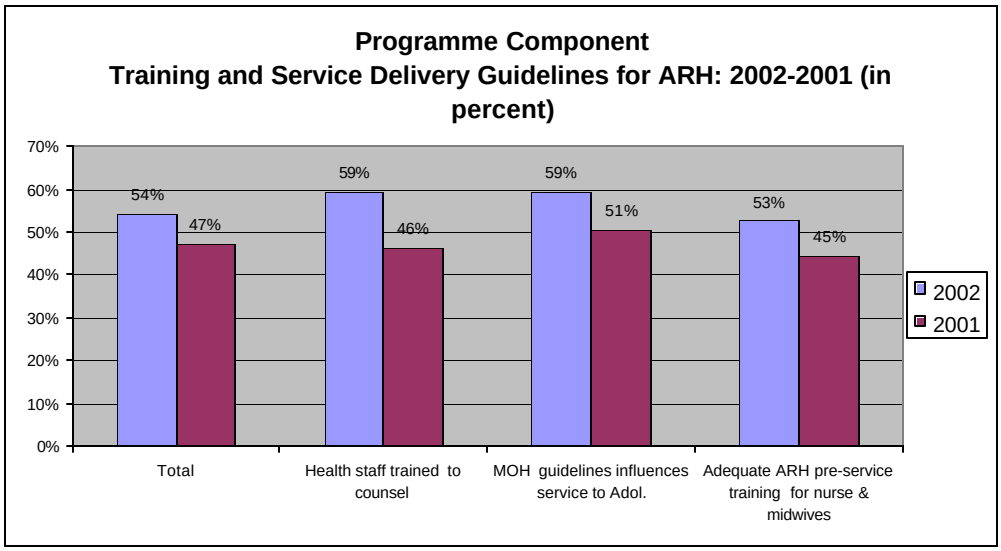
Information and services

Information and services includes eight items with a wide range in scores, from a high of 73 percent for sexually transmitted infections (STIs)/HIV/AIDS being part of educational efforts to a low of 27 percent for the availability of post-abortion counseling for youth. The lower scores indicate that contraceptives are not readily provided to young people in clinics and other venues, that young people do not have ready access to emergency contraceptive pills (ECP), and that they do not have access to contraceptives through community-based distribution channels. In general, the access to STI/HIV/AIDS services, including access to condoms, was considered better than access to contraceptives.



Note: The columns reflecting the total score are for all program components combined.

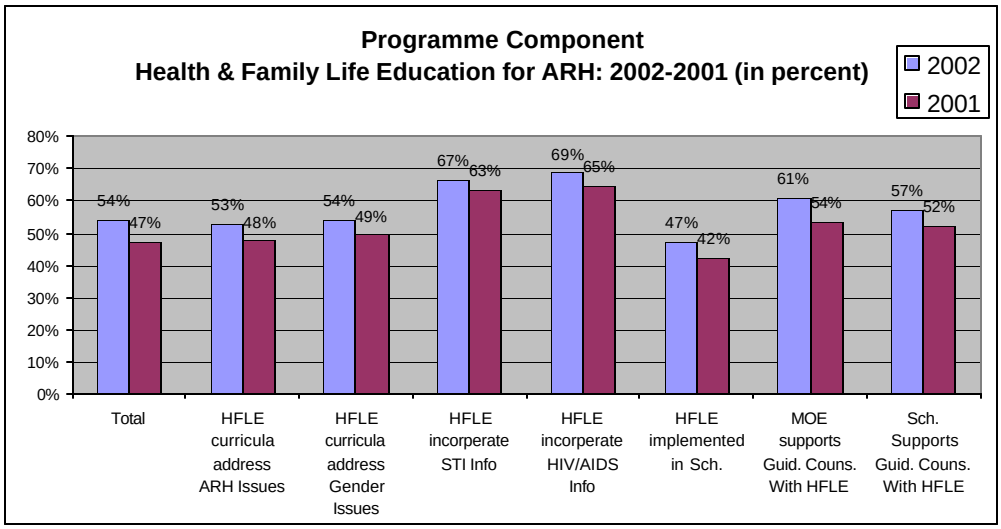
Training and services delivery



Note: The columns reflecting the total score are for all program components combined.

The three items included in training and service delivery guidelines part of the program component had similar scores, ranging from 53 percent to 59 percent. Respondents particularly felt that providers need more adequate pre-service training for working with adolescents.

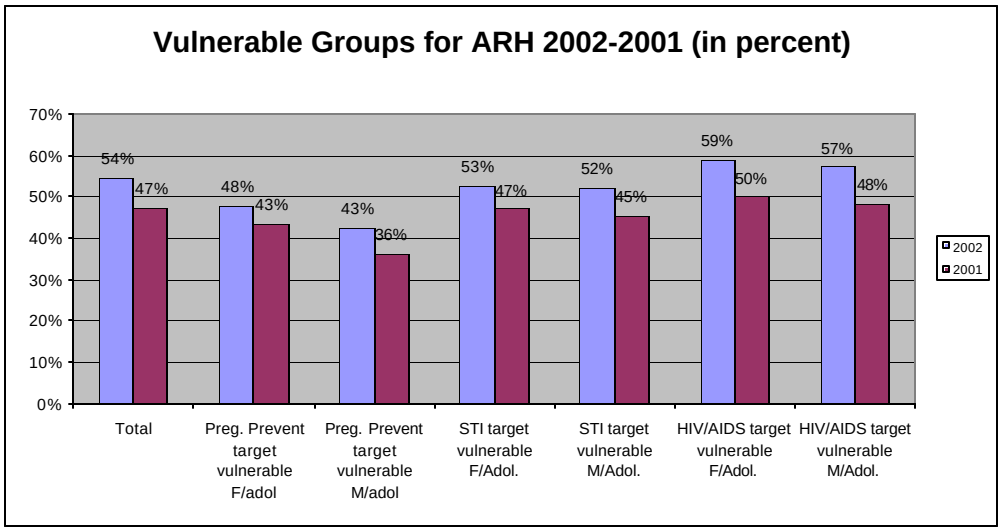
Health and Family Life Education



Note: The columns reflecting the total score are for all program components combined.

The seven items under the Health and Family Life Education (HFLE) part of the program component indicate that respondents consider the strongest components of HFLE to be the inclusion of STIs and HIV into the curricula. The support of the Ministry of Education (MOE) and school administrators is considered fair (61% and 57%, respectively). Respondents did not feel that HFLE is being effectively implemented in schools (47%), or that the curricula take gender issues into account or that they are appropriate to address ARH issues in the country.

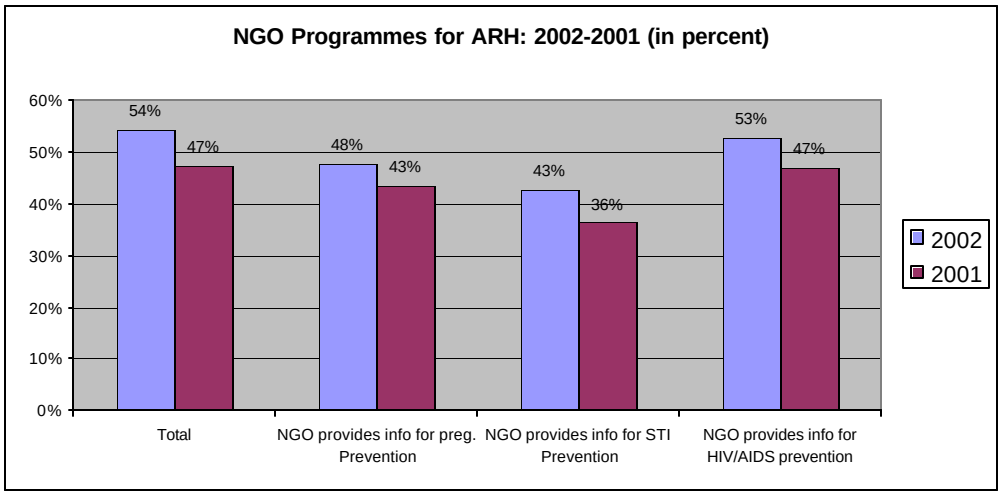
Vulnerable Groups



Note: The columns reflecting the total score are for all program components combined.

The six items related to the vulnerable groups part of the program component indicate that the policy environment is weaker for reaching vulnerable female and male youth with pregnancy prevention efforts than for reaching vulnerable groups with STI and HIV preventions efforts.

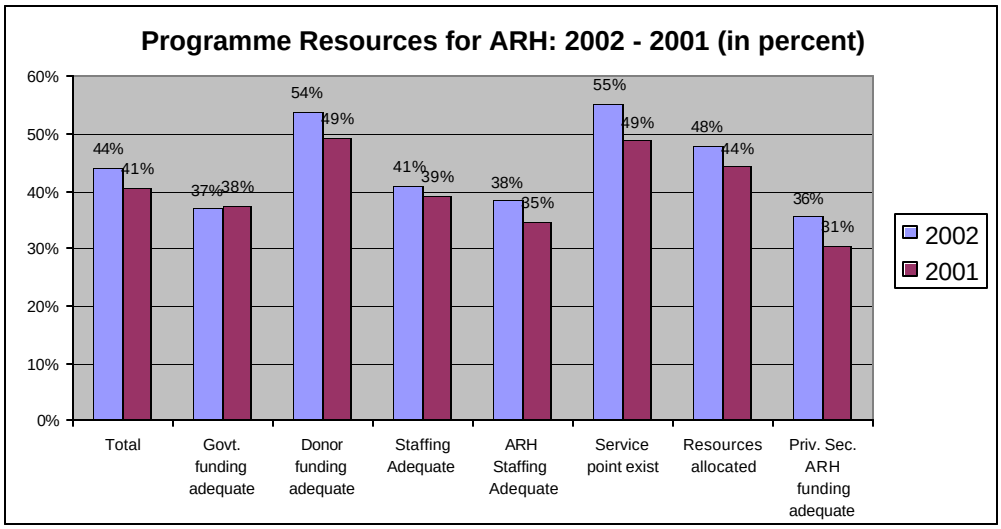
NGO Programs



Note: The columns reflecting the total score are for all program components combined.

The three items related to the NGOs part of the program component indicate that the greatest NGO efforts are in programs to prevent the spread of HIV although NGOs could be doing much more to provide pregnancy, STI, and HIV prevention information and services to youth.

Program Resources (41% in 2001 and 44% in 2002)



The resources component received the lowest score in both 2002 and 2001 and only increased by 3 percentage points—the lowest of all of the PES components. Two of the seven items in this component received scores above 50 percent: funding from donor sources is generally adequate (54%) and enough service points and providers exist for reasonable access by most clients (55%). Three items had scores

falling below 40 percent: funding from government sources is generally adequate, staffing for ARH service provision is generally adequate, and funding/other support for ARH from private sector is generally adequate. "Funding from government sources is generally adequate" actually scored one point less in 2002 than 2001, dropping to 37 percent from 38 percent.

Comparing Components

Scores increased in all components of the Expanded PES from 2001 to 2002. The total Expanded ARH PES increased by a mere 7 percentage points – moving from 51.0 percent of the maximum of 100 percent in 2001 to 58.3 percent in 2002. Closer analysis of the performance of individual items in the seven components indicates important differences. Table 2 shows the items within the seven components that received scores of 65 percent or higher and those that received 50 percent or lower. Political support for ARH and Policy Formulation had the largest number of items scoring 65 percent and above. In contrast, the Program component had the included the largest number of items scoring 50 percent or lower.

Table 2. Items with High (65% or above) and Low (50% or lower) Scores in the Expanded ARH PES, by Component

Items with scores of 65% or higher	Items with scores of 50% or lower
Political Support for ARH (10 items) Government supports HIV/AIDS Public supports HIV/AIDS Media permitted Political parties support HIV/AIDS Recognition of teen pregnancy as a problem by top planning bureaus Recognition of HIV/AIDS as a problem by top planning bureaus	**Political Support for ARH** Religious organizations support family planning
Policy Formulation (15 items) Youth policy exists HIV/AIDS policy exists Program goals exist Strategies exist Other ministries are involved in policy development Policy supports HFLE/IEC programs Policy supports ANC programs Policy supports STI programs Policy supports pregnant students finishing school	
Evaluation and research (7 items) Research is used in policy formulation	**Evaluation and research** Statistics are disseminated to NGOs, CBOs, etc.
	Organizational structure (6 items) A national coordinating body exists that engages ministries to assist with appropriate services

	Legal and regulatory environment (3 items) Providers are not restricted from serving adolescents
Programs (27 items) STI/HIV/AIDS information is part of education efforts HFLE incorporates STI information HFLE incorporates HIV/AIDS information	**Programs** Contraceptives are provided to adolescents Postabortion counseling is part of youth programs ECP is available to adolescents CBD systems exist HFLE is implemented in schools Pregnancy prevention is targeted to vulnerable groups of young females Pregnancy prevention is targeted to vulnerable groups of young males NGOs provide information for pregnancy prevention NGOs provide information for STI prevention
	Resources (7 items) Government funding is adequate Staffing for service provision is adequate ARH staffing is adequate Resources allocated Private sector ARH funding is adequate

While *political support, policy formulation and evaluation/research* are fairly strong (with scores between 60% and 70%), the other four components of the policy environment for ARH received scores in the range of 44 to 56 percent. The areas of strongest perceived improvements in the Expanded ARH PES included political support, policy formulation and organization. Some respondents noted that this political will needs to be translated into action. One respondent noted, "Political will needs to be translated into prompt and comprehensive ACTION on the ground." Another respondent noted the need for stronger implementation of programs for ARH. "Despite acceptance and knowledge of the program needs, at the national level, program implementation remains weak."

The component of evaluation and research was scored high. One item received a score of 65% or higher (data are used in policy formulation), and one scored 50% or lower (statistics are disseminated to NGOs, CBOs, etc.). One respondent suggested ways to make the information more accessible, saying, "More attention and resources need to be channeled to increase access to and decentralize data and information via user friendly mechanisms, such as a website or parish level resource centers."

A main policy issue for ARH that affects programs continues to be provision of services to minors (under age 16). The MOH has drafted and field tested guidelines for providers on serving minors. The guidelines have received approval from groups of guidance counselors and parents; however, the guidelines are currently tabled in Parliament. Meanwhile, providers are still wary of serving adolescents and many fear prosecution if they do. One respondent said that the "Policy guidelines urgently need to be finalized and effectively disseminated to increase young people's access to services."

Implementation of HFLE needs to be strengthened. One respondent noted that the "non-implementation of effective HFLE programs seriously impede the programs' curricula. The materials that exist are mainly unused or poorly used." Another respondent called for increased political will, resources, and coordination for implementing HFLE. "The curricula are developed, but an ad hoc response continues to exist in the NGO and government sectors. We need political will and resources to effectively scale up what works (especially in relation to HFLE and the formal education sector). We also need to strengthen coordination mechanism(s) (e.g., National HFLE Advisory Committee)."

In the program area, continued attention is needed to improve access to emergency contraceptive protection and care for vulnerable groups. One respondent noted, "The policies are in place; the lack of coordination and effective outreach to those highest at risk persists. The approach to children in care remains poor." Another added, "Much more needs to be done [to reach vulnerable groups]."

The area of weakest perceived improvement was in the area of resources (with a 3 percentage point increase in 2002 over 2001). A respondent noted the need for additional resources, saying, "A lot more needs to be done in all areas. The problem is much more urgent and grave than the resources allocated to rectify the issues."

One might conclude from this analysis that the policy environment for adolescents and their reproductive health has much room for improvement. Improvement is especially needed in the area of Programs, in the legal and regulatory environment, evaluation and research, and organizational structures for ARH.

IV. Conclusion

Analysis of the 2002 Expanded PES data provides evidence of improvements in the degree to which the policy environment in Jamaica is supportive of effective reproductive health policies and programs for adolescents. While not a perfect instrument, the Expanded ARH PES provides a measure that is useful for evaluating the changing status of the policy environment and reflects the initiatives that have been undertaken in the past few years to improve ARH in Jamaica. The government and donors have recognized the need among adolescents for reproductive health information and services. Evidence of this recognition is seen in:

- The MOH's *Strategic Framework for Reproductive Health 2000–2005* where adolescents are noted as a primary target group for reproductive health services (MOH, 2000).
- Donor funding has increasingly been targeted to ARH activities.
- The USAID-funded project Youth.now is being implemented in a number of parishes in Jamaica.
- Two working groups—one co-chaired by the MOH and the Planning Institute of Jamaica (PIOJ) and another of Parliamentarians—are addressing policy issues related to ARH.
- The 1999 *Jamaica Family Planning Service Delivery Guidelines* (MOH and NFPB, 1999) includes a chapter on serving adolescents.

Still, the Expanded ARH PES for 2002 was 58 percent, up only 7 percentage points from 2001 indicating that the policy environment for adolescents, as measured by both the expanded and the original set of items for the seven components, has much room for improvement.

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Appendix A. List of Participants

1. Dr. Alfred Brathwaite, STD Technical Consultant, Epidemiology Unit, MOH
2. Dr. Karen Lewis-Bell, Director, Family Health Division, MOH
3. Dr. Tina Hilton-Kong, Medical Officer (Health), KSA, MOH
4. Dr. Elizabeth Ward, MOH
5. Dr. Yitades Gebre, MOH
6. Nurse Rose Scringer, MOH
7. Dr. Michele Roofe Regional Technical Director, NERHA
8. Mrs. Paulene Allen-Mitcelle, Regional Programme Development Officer, NERHA
9. Michelle Harris, Deputy Regional Technical Director, SERA
10. Dr. Kyaw Tint, Medical Officer (Health)
11. Ms. Verlie James – Parish Manager Westmoreland
12. Dr. Sheila Campbell Forrester, Regional Director, WRHA, MOH
13. Dr. Beverley Wright Medical Officer (Health) – Manchester Health Department
14. Dr. Jeremy Knight – Medical Officer (Health) Portland
15. Dr. Sonia Copeland, Medical Officer(Health) Clarendon Health Department
16. Dr. Derick Ledford Medical Officer (Health) St. Elizabeth Health Department
17. Dr. Douglas McDonald, Senior Medical Officer, Victoria Jubilee Hospital
18. Mrs. Ellen Radlein, Director, Projects & Research, NFPB
19. Mrs. Eugenia McFarquahar, Health Consultant
20. Dr. Olivia McDonald, Executive Director, NFPB
21. Mrs. Beryl Chevannes, Health Consultant
22. Professor Hugh Wynter, Fertility Management and Research Unit, UWHI
23. Ms. Pansy Hamilton, Fertility Management and Research Unit, UWHI
24. Dr. Peter Weller, University Health Centre
25. Dr. Errol Daley, President, MAJ
26. Mrs. Iris Wilson, President, NAJ
27. Mrs. Sarah Newland-Martin, Director, Kingston YMCA
28. Rev. Webster Edwards, Director, Operation Friendship
29. Mrs. Beryl Weir, Director, The Women's Centre of Jamaica Foundation
30. Mrs. Zoe Simpson, Women's Center of Jamaica Foundation
31. Mrs. Sonita Abrahms, Addition Alert
32. Dr. Peter Swaby, Hope Worldwide Jamaica
33. Dr. Faye Whitbourne, ACROSTRAD
34. Ms. Ann-Marie Bonner, Policy Analysis, Office of the Prime Minister
35. Mr. Ian McKnight/Dr. Robert Carr, JAS
36. Mr. Joseph Robinson – Executive Director, ASHE
37. Mrs. Peggy Scott, Jamaican Family Planning Association
38. Mrs. Utilia Burrell, Rural Family Support Organization, Clarendon
39. Mrs. Jennifer Knight-Johnson, USAID
40. Mrs. Claire Spence – USAID
41. Ms. Penny Campbell, UNICEF
42. Mrs. Ruth Jankee, GTZ
43. Mr. Dervan Patrick, Health Specialist, UNFPA
44. Dr. Manuel Pena, PAHO

The following persons were also invited to participate but were unavailable, declined due to pressure of work, or alternatively, they passed their questionnaires to persons who were already in receipt of questionnaires:

45. Dr. Blossom Anglin-Brown, UWI, Mona
46. Dr. Deloris Brissett, Ministry of Education
47. Nurse G. Omphroy-Spencer, Victoria Jubilee Hospital
48. Dr. J. Fredericks, OB/GYN, University Hospital
49. Dr. Carol Rattray , OB/GYN, University Hospital
50. Dr. Harris Fletcher, Grabham Society, University Hospital
51. Mrs. Grace Allen-Young, MOH
52. Ms. Natalie Campbell, NCYD (in Ministry of Education)
53. Mrs. Kerida Scott-McDonald, UNICEF
54. Mrs. Lois Owen, Pharmacists Council
55. Mr. Robert Bryan Executive Director, SDC
56. Dr. T. Alexander, Cornwall Regional Hospital
57. Dr. Dawn Padilla, MO (H) St. Catherine Health Department, SMO Spanish Town Hospital
58. Ms. Lois Hue, Red Cross, St. Catherine
59. Mrs. Claudette Pious, Children First , St. Catherine
60. Dr. Michael Coombs Regional Technical Director, SRHA

Appendix B. 2002 Expanded ARH Policy Environment Score Questionnaire

Respondent Guide

The following comments are intended to assist you in responding to the items on the questionnaire.

1. The last PES was done in 2000. ***"Status now"*** speaks to 2002 and ***"status one year ago"*** is 2001
2. Scoring - All the items are scored on a 0 – 4 scale with 4 being strongest and 0 being weakest.
3. The previous PES looked at FP, STI/HIV/AIDS. This survey focuses on the adolescents alone and additional items are added, capturing more needed information on the target group.

Political Support

4. ***"Planning bureaus"*** item 11, speaks to bodies such as PIOJ and the MOH Planning Unit.

Programme Components

5. ***"Community-Based Distribution (CBD) systems"*** (item 8) speaks to those communities where individual members of the community provide FP services for short periods of time. These individuals also refer to the local health centers for follow-up service.
6. HFLE curricula speak to the MOE curricula introduced into the Primary and Secondary schools.
7. "Vulnerable groups" (items 23-28) – youth at risk. E.g. youth living on the street, those unemployed, dropped out of school, handicap/persons living with disabilities.

Instructions.

Rate each item twice – once to reflect the current status (2002) and once to indicate the status a year ago (2001). The items are scored on a 0-4 scale with 0 being weak and 4 being strong. Please place the appropriate score in the box beside the corresponding item.

(Scoring: 0=weak; 4 = strong)		
I. POLITICAL SUPPORT	**Status Now 2002**	**Status 1 Year Ago**
1. High-level national government support exists for effective policies and programmes.		
2. High-level national government support exists for effective policies and programmes to provide family planning to unmarried adolescents.		
3. High-level national government support exists for effective policies and programmes for prevention of HIV/AIDS among adolescents.		
4. Public opinion supports effective policies and programmes.		
5. Public opinion supports effective policies and programmes to provide family planning to unmarried adolescents.		
6. Public opinion supports effective policies and programmes for prevention of HIV/AIDS among adolescents.		
7. Media campaigns are permitted.		
8. Political parties support effective policies and programmes.		
9. The problem of pregnancy among adolescents is recognized by top planning bureaus.		
10. The problem of HIV/AIDS among adolescents is recognized by top planning bureaus.		
11. The problem is recognized by top planning bureaus.		
12. Major religious organizations support effective policies and programmes to provide family planning to unmarried adolescents.		
13. Major religious organizations support effective policies and programmes for prevention of HIV/AIDS among adolescents.		

II. POLICY FORMULATION	**Status Now 2002**	**Status 1 Year Ago**
1. A favorable national policy exists.		
2. A favorable national youth policy exists.		
3. A favorable national ARH policy exists.		
4. A favorable national HIV/AIDS policy exists that includes aolescentsadolescents.		
5. Formal programme goals exist.		
6. Specific and realistic strategies to meet goals exist.		
7. Youth policies incorporate male adolescent reproductive health issues.		
8. Youth policies address male adolescent reproductive health.		
9. Ministries other than Health are involved in policy formulation.		
10. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector and special interest groups.		
11. Policy dialogue and formulation involves religious organizations		
12. Government policy supports family life education and other IEC efforts for youth		
13. *Government/ national policy supports provision of contraception for adolescents.*		
14. *Government/national policy supports provision of antenatal care for pregnant adolescents*		
15. Government/national policy supports provision of STI treatment for adolescents		
16. *Government/ national policy supports pregnant teenagers continuing their education*		
17. *Government/national policy supports students with HIV continuing in school*		
III. ORGANIZATIONAL STRUCTURE	**Status Now 2002**	**Status 1 Year Ago**
1. A national coordinating body exists that engages various ministries to assist with appropriate services. (If none, enter zero.)		
2. Ministries other than Health are mandated to help with programme implementation.		
3. A mechanism exists at the health region level to coordinate planning, resource allocation and implementation of ARH activities.		
4. NGOs are formally included in policy deliberations.		
5. The private sector is formally included in policy deliberations.		

6. Religious organizations are formally included in policy deliberations.

IV. LEGAL AND REGULATORY ENVIRONMENT	Status Now 2002	Status 1 Year Ago
1. There is a favorable legal and regulatory climate for ensuring that unmarried adolescents may receive services for family planning.		
2. Pregnant adolescents are allowed to continue with their education.		
3. Providers are free from unnecessary legal and regulatory restrictions (i.e., services available to adults are available to adolescents as well).		

V. PROGRAMME RESOURCES	Status Now	Status 1 Year Ago
1. Funding from government sources is generally adequate.		
2. Funding from donor sources is generally adequate.		
3. Staffing for service provision is generally adequate.		
4. Staffing for ARH service provision is generally adequate.		
5. Enough service points and providers exist for reasonable access by most clients.		
6. Resources are allocated by explicit priority guidelines.		
7. Funding/other support for ARH from private sector is generally adequate.		

VI. PROGRAMME COMPONENTS	Status Now	Status 1 Year Ago
1. Contraceptives are provided for single adolescents in the usual service delivery points, as well as in schools, youth centers and other places where youth are found.		
2. Counselling services in family planning for single adolescents are offered not only in the usual service delivery points, but also elsewhere, such as in schools, youth centers, or other places where youth are found.		
3. STD/AIDS information is an integral part of educational efforts.		
4. Condoms are easily available to youth through channels that youth have access to, e.g. pharmacies, clinics, vendors.		
5. Post-abortion counseling is an integral part of the youth programme.		
6. Emergency contraceptive protection (ECP) is available to unmarried adolescents.		
7. STI services are available to unmarried adolescents		
8. Health staff arestaffs are trained to counsel youth in sexuality and reproductive health matters.		

VI. PROGRAMME COMPONENTS (cont.)	Status Now 2002	Status 1 Year Ago
9. Community-based distribution (CBD) systems exist and employ youth (male and female) distributors. (If no CBD system exists, enter zero.)		
10. HFLE curricula are appropriate to address ARH issues in the country		
11. HFLE curricula take gender issues into account.		
12. HFLE curricula incorporate STI information		
13. HFLE curricula incorporate HIV/AIDS information		
14. HFLE is being effectively implemented in schools		
15. Guidance counselors receive support from the MOE to teach HFLE		
16. Guidance counselors receive support from school administrators to teach HFLE		
17. MOH's service delivery guidelines for serving minors influences service delivery for adolescents		
18. Pre service training in ARH for nurses and midwives is adequate.		
19. Pregnancy prevention efforts are adequately targeted to vulnerable groups of female adolescents.		
20. Pregnancy prevention efforts are adequately targeted to vulnerable groups of male adolescents.		
21. STI control efforts are adequately targeted to vulnerable groups of female adolescents.		
22. STI control efforts are adequately targeted to vulnerable groups of male adolescents.		
23. HIV/AIDS control efforts are adequately targeted to vulnerable groups of female adolescents.		
24. HIV/AIDS control efforts are adequately targeted to vulnerable groups of male adolescents.		
25. NGOs participate in the provision of information for pregnancy prevention.		
26. NGOs participate in the provision of information for STI prevention.		
27. NGOs participate in the provision of information for HIV/AIDS prevention.		

Comments: _____

VII. EVALUATION AND RESEARCH	Status Now 2002	Status 1 Year Ago
1. A regular system of service statistics exists and functions adequately.		
2. A system exists to monitor secondary data sources (surveys, censuses, local studies, etc.) for the benefit of policy guidance.		
3. A system exists to bring evaluation and research results to management's attention.		
4. Special studies are undertaken to address leading policy issues.		
5. *Service statistics are?? effectively disseminated to NGO, CBO and private sector*		
6. *Research and service data/information are used to inform policy formulation*		
7. *Research and service data/information are used to inform decision making*		

Comments:

Appendix C. 2002 Analysis of the Original ARH PES Data Comparing 2001 and 2002

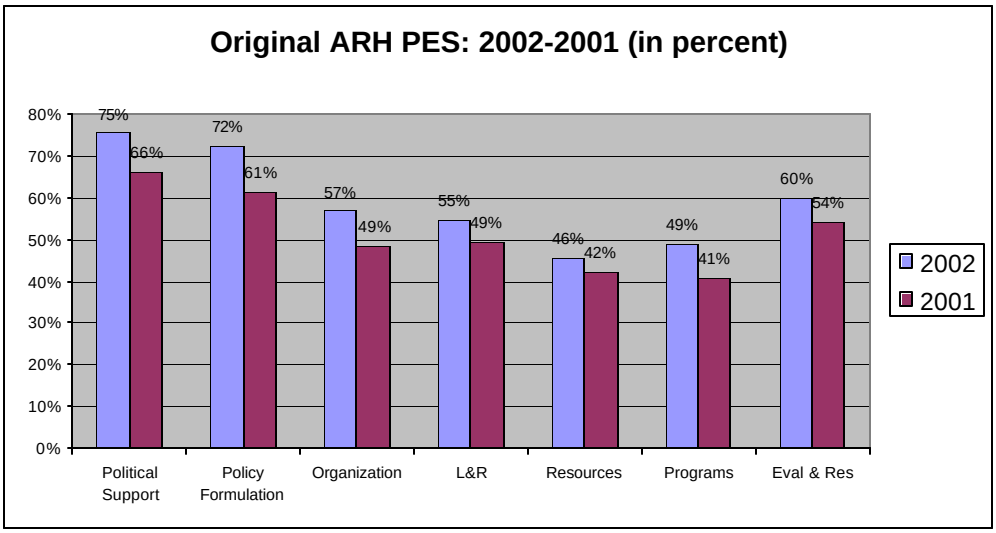
Table 2. Comparison of Original [1] Adolescent Reproductive Health (ARH) Policy Environment Scores (PES) by Program Components: 2002/2001

Component	2002	2001	Change (in % points)
All components	**59.1**	**51.8**	**7.3**
Political Support	75	66	9.0
Policy Formulation	72	61	11.0
Organization	57	49	8.0
Legal and regulatory	55	49	6.0
Resources	46	42	4.0
Programmes	49	41	8.0
Evaluation and research	60	54	6.0

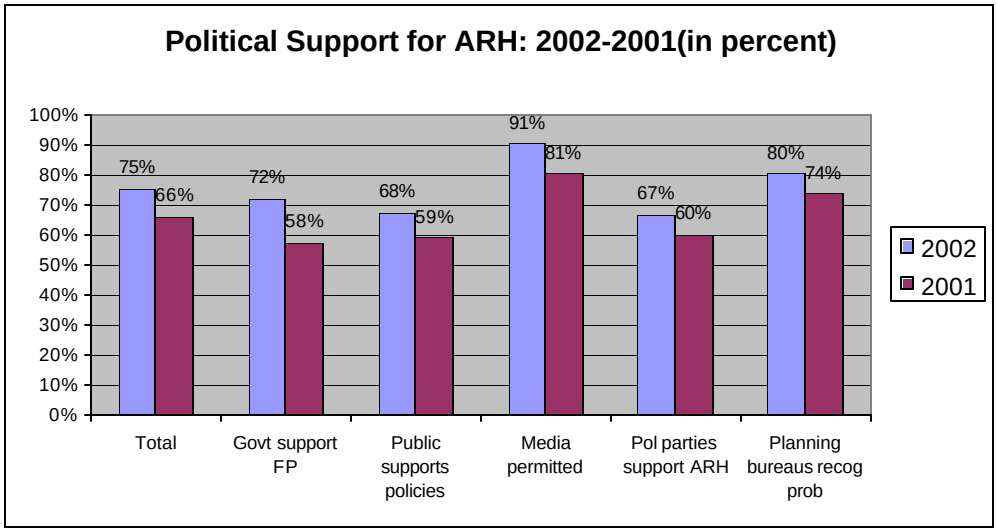
Note: Values can range from 0 – 100.

[1]The Original ARH PES includes the same items as in the 1999 and 2000 rounds of the PES.

The original ARH PES (using the items for ARH in the 2000 and 1999 rounds of the PES) was rated 7.3 percentage points higher for 2002 than for 2001, which indicates an improvement in the policy environment for ARH in Jamaica. The scores for all seven components, namely political support, policy formulation, organization, legal and regulatory, resources, programs, and evaluation and research showed improvement in 2002 compared to 2001. Political support and policy formulation achieved scores above 70 percent. These two components showed significant improvements of 11 percentage points each. The other five components showed scores from a low of 46 percent for the resource component to a high of 60 percent for the evaluation and research component. The range of increase for these five components was between 4 percentage points for resources to 8 percentage points for organizations and programs.

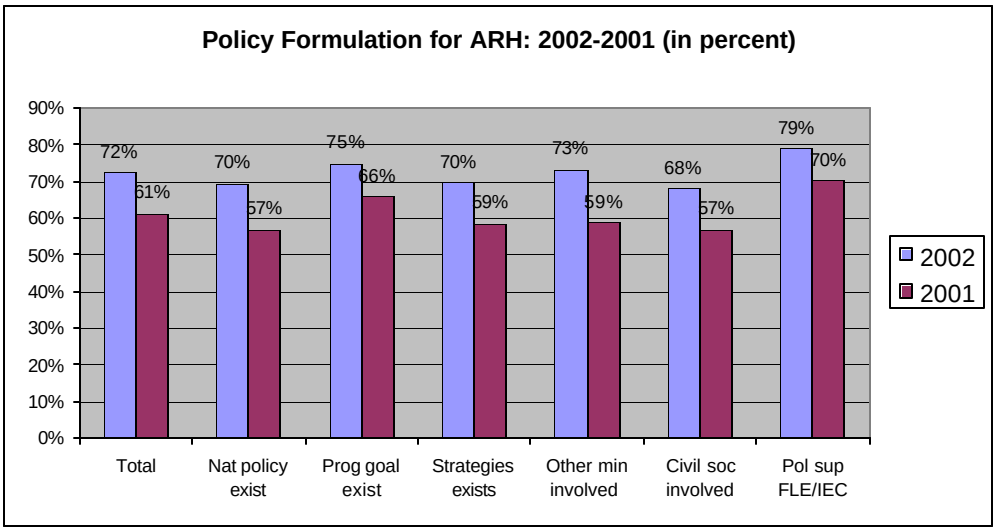


Political Support (66 percent in 2001 and 75 percent in 2002)



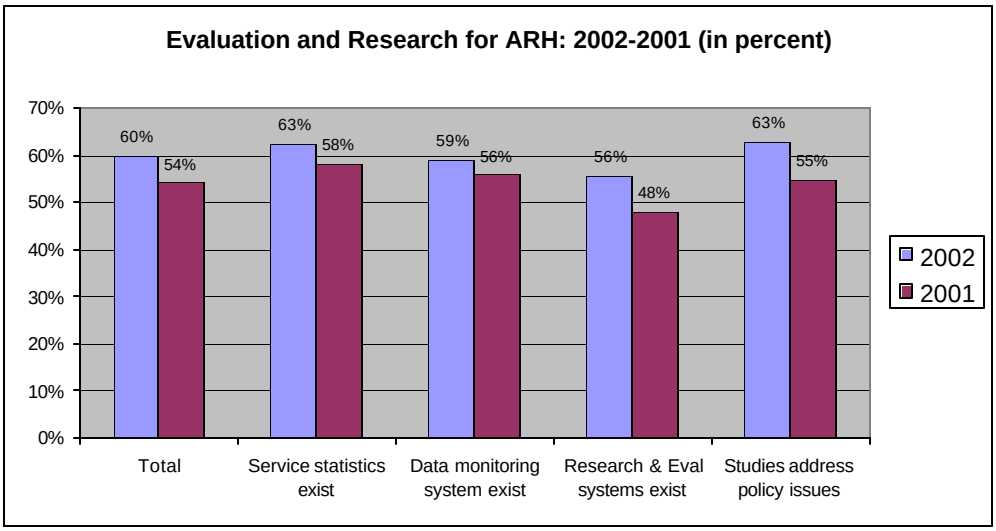
The political support component ranked highest in the original ARH PES at 75 percent for 2002, an 11 percentage point increase between 2001 and 2002. The category, "high-level national government support exists for effective policies and programs," showed the largest increase, 14 percentage points. The media as a supporting agent received a score of 91 percent. Respondents perceived that the problems of pregnancy and HIV/AIDS are highly recognized by top planning bureaus, with this category scoring 80 percent. Political parties' support for policies and programs was the lowest ranking item in this category, with a score of 67 percent.

Policy formulation (61 percent in 2001 and 72 percent in 2002)



Policy formulation was the second highest-ranking category, with a score of 72 percent and an 11 percentage point increase from 2001. All the items under the policy formulation components showed significant increase. Five items had scores between 70 and 79 percent. Two items, "ministries other than health are involved in policy formulation" and "a favorable national policy exists," show increases in scores of 14 and 13 percentage points, respectively. Respondents' perceptions of the involvement of civil society in policy dialogue and formulation were moderate, with a score of 68 percent, although this item showed an overall increase of 11 percentage points.

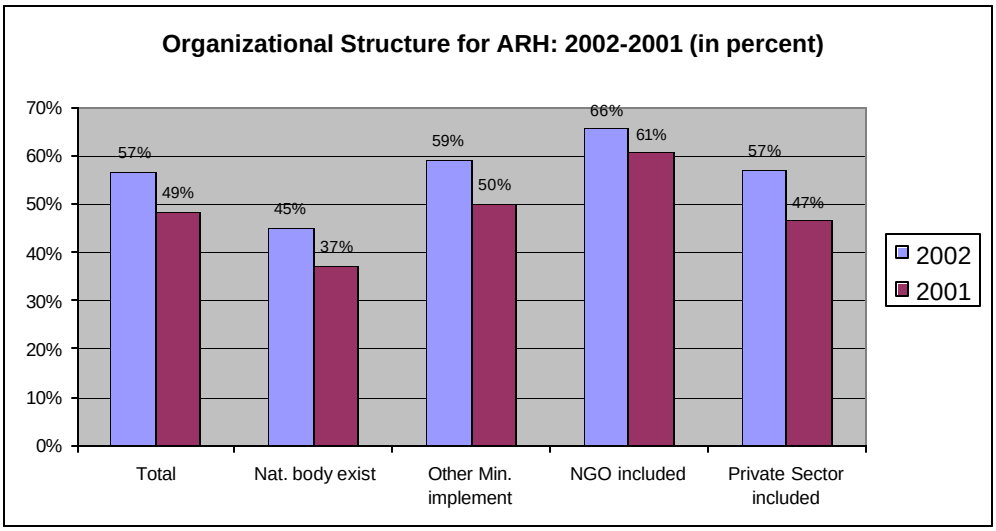
Evaluation and Research (54 percent in 2001 and 60 percent in 2002)



Evaluation and research was the third highest ranked component with a score of 60 percent. This component showed a 6 percentage point increase from 2001. Improvement in this component in part resulted from the perception that studies are undertaken to address leading policy issues and the existence of a regular system of service statistics, which functions adequately. Both items showed scores of 63

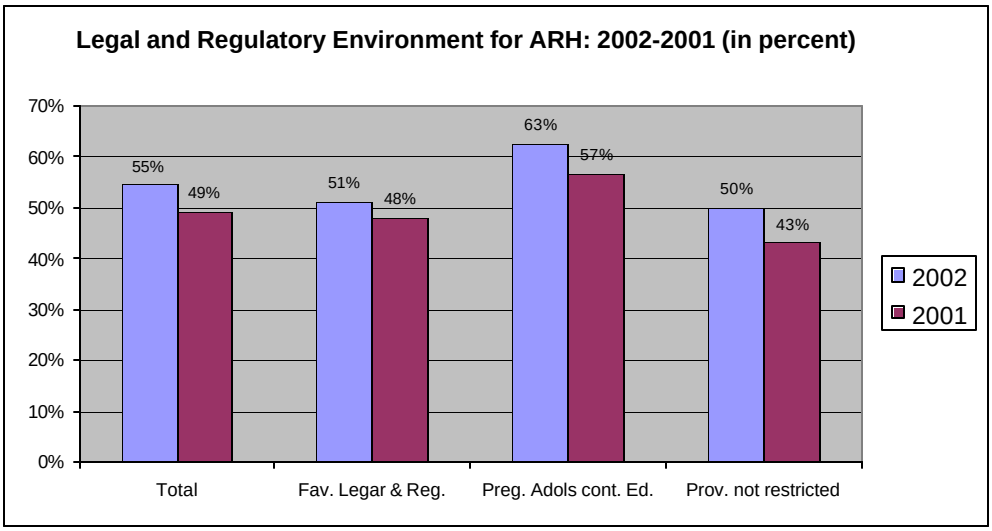
percent. The absence of a proper data system to monitor secondary data sources for the benefit of policy guidelines is reflected in the mere 3 percentage point increase for this item.

Organizational structure (49 percent in 2001 and 57 percent in 2002)



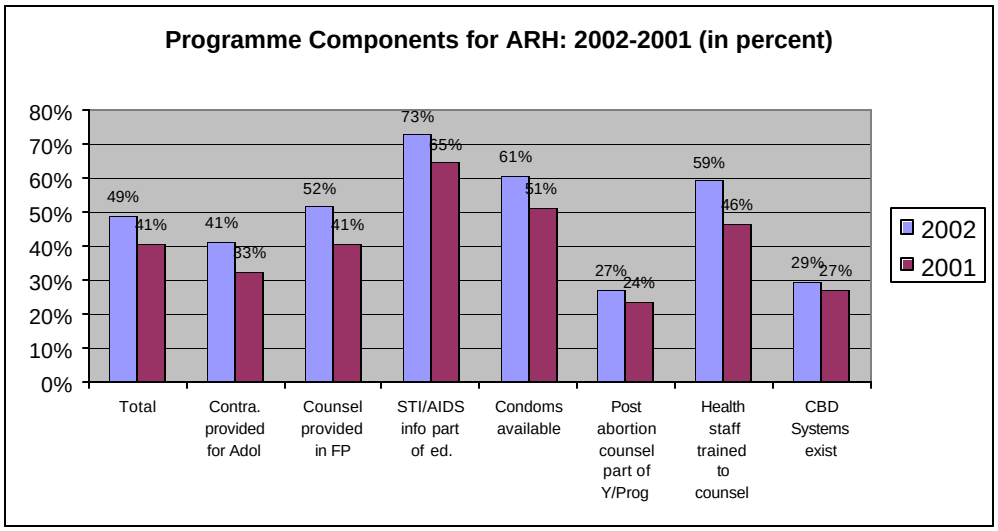
Organizational structure is the fourth highest ranked component in the original ARH PES with a score of 57 percent for 2002 (in increase of 8 percentage points over 2001). The inclusion of the private sector in the policy deliberations shows a 10 percentage point increase, which is the largest increase for this component. There was also a 9 percentage point increase for the item indicating that ministries other than health are mandated to help with program implementation. Respondents felt that there is still a need for a national coordinating body to engage the various ministries to assist with appropriate services. This item received a score of 45 percent.

Legal and regulatory (49 percent in 2001 and 55 percent in 2002)



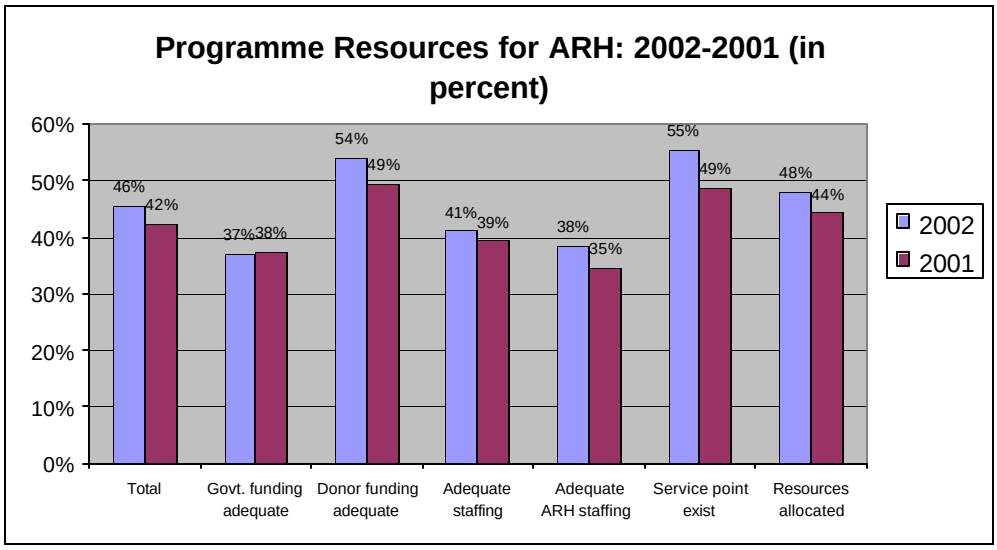
The component of legal and regulatory environment ranked fifth in the original ARH PES with a score of 55 percent in 2002 (a 6 percentage point increase from the 2001 score). All three items in this component showed an increase of between 3 and 6 percentage points, indicating some, but not dramatic change in the legal and regulatory environment for ARH in Jamaica. The strongest item in this component is that pregnant adolescents can continue their education (63%).

Program components (41 percent in 2001 and 49 percent in 2002)



The program component is one of two components that received a score of less than 50 percent (it received a score of 49% in 2002 compared with 41% in 2001). This 8 percentage point increase over 2001 indicates that the program component is getting stronger although it has much room for improvement Factors contributing to this increase are reflected in the respondents' perception that health staff are trained to council youth in sexual and reproductive health matters (a 13 percentage point increase), counseling is provided on family planning for young adolescent outside of the health center (an 11 percentage point increase), and condoms are available to adolescents through channels to which adolescents have access (a 10 percentage point increase). CBD systems to provide youth with contraceptives (29%) and post abortion counseling as a part of the youth program (27%) were the lowest rated items and showed very small increases (2 and 3 percentage point increases, respectively).

Program Resources (42 percent in 2001 and 46 percent in 2002)



Program resources received the lowest ranking in both the 2001 and 2002 original ARH PES, with scores of 42 percent and 46 percent. The increase in 2002 over 2001 represented a 4-percentage point increase. Two items—"donor funding is adequate" (54%) and "service points and providers exist for reasonable access by most clients" (55 %)—were the only two items that had scores of more than 50 percent. The increases for six of the seven items in the component were between 2 and 4 percentage points The item focusing on adequate government funding actually showed a 1 percentage point decrease from 2001 to 2002—from 38 to 37 percent.